STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 01	(X3) DATE S COMPL		
		15G606	A. BUII B. WIN			05/14/	2013
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010000							
	Survey was cond	ode Recertification ducted by the Indiana t of Health in accordance 3.470(j).	K0:	10000			
	Survey Date: 05	5/14/13					
	Facility Number	: 001175					
	Provider Numbe						
	AIM Number: 1						
	Surveyors: Marl	k Caraher, Life Safety					
	Code Specialist	& Robert Sutton, Life					
	Safety Code Spe	cialist Trainee					
	At this Life Safe REM-Indiana, Ir compliance with Participation in Number 1483.470 and the 2000 Edit Protection Associately Code (LS Residential Boar This one story by was determined The facility has a smoke detection and in all living the safe to the safe t	ty Code survey, nc. was found not in Requirements for Medicaid, 42 CFR (j), Life Safety from Fire ition of the National Fire ciation (NFPA) 101, Life C), Chapter 33, Existing d and Care Occupancies. uilding with a basement to be fully sprinklered. a fire alarm system with in corridors, in bedrooms areas. The facility has a I had a census of 7 at the					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		A. BUII B. WIN	LDING	01	COMPL: 05/14/	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	Score (E-Score) Alternative Appr Chapter 6, rated E-Score of 1.9. Quality Review I Safety Code Spe on 05/16/13. The facility was	e Evacuation Difficulty using NFPA 101A, roaches to Life Safety, the facility Slow with an by Robert Booher, Life cialist-Medical Surveyor found not in compliance entioned regulatory evidenced by the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet Page 2 of 11

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF I	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606 NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		ADDRESS, CITY, STATE, ZIP CODE	COMPLETED 05/14/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K010130	Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, if not required by the Code, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation with the Program Director during a tour of the facility from 11:40 a.m. to 12:15 p.m. on 05/14/13, the portable fire extinguisher located in the kitchen had an affixed inspection and maintenance tag lacking a monthly inspection for February 2013. Based on interview at the time of observation, the Program Director stated no other	K010130	The Home Manager will be retrained to include up to datequality checks and inspections on the monthly Homanger/PD checklist. If anyproblems should arise, the Home Manager will inform the appropriate maintenancepersonnel. The Home Manager will ensurthat all fire extinguishers aremaintained and inspected within the appropriate time frames (annually or more)as needed. Ongoing, the Home Manager complete the monthly HomeManage/PD checklist are request that any repairs be min the appropriatetimeframe. Responsible Party: Home Manager Completion Date: June 7, 201	will and ade	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet

Page 3 of 11

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G606		LDING	01	COMPL 05/14/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222			•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	documentation of extinguisher inspreview and acknowledge in inspection for Fe	of monthly fire bections was available for owledged the monthly bruary 2013 for the portable fire extinguisher					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet Page 4 of 11

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	R/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC			ON (X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		15G606	B. WIN			05/14/2	2013
	PROVIDER OR SUPPLIER		•	3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K01S051	Exception No 1: No interconnected sor requirements of 3 less than one may floor arranged to smoke detector and Exception No. 2: continuously sour the authority having Based on record interview; the fact 1 manual fire ala maintained in act 9.6. Section 9.6. system shall be in maintained in act applicable requirements and policable requirements. Section 7-1.1.2 so the corrected. The could affect all could affect	The system is provided in Section 9.6, 33.2.3.4.1. Where there are moke detectors meeting the is 3.2.3.4.3 and there is not nual fire alarm box per continuously sound the larms. Other manually activated adding alarms acceptable to ang jurisdiction. The review, observation and cility failed to ensure 1 of its systems was cordance with Section 1.4 states a fire alarm anstalled, tested and cordance with the rements of NFPA 72, tates system defects shall ais deficient practice lients, staff and visitors.	KO	IS051	Indiana MENTOR in conjunction with USAutomatic, will ensured the smoke detector that 'failed the most recent functional test of themanual fire alarm system replaced and/or repaired. Ongoing, the Area Director, in conjunction with the Maintenan Supervisor will review all report of required testing completed by USAutomatic to ensure that any and all needed follow up is completed and ontime. This repair was confirmed as being completed on 5/18/2013 (see attachments). Responsible Party: Indiana MENTOR Maintenance Completion Date: April 14, 201	that ing n is	06/13/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet Page 5 of 11

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606 A. BUILDING B. WING			COMPLETED 05/14/2013			
PROVIDER OR SUPPLIER		D. WIN	STREET A	.DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
SUMMARY ST (EACH DEFICIENCE REGULATORY OR detector in the be- room was listed a recent functional fire alarm system the time of record Director stated nowas available for subsequent repair aforementioned a acknowledged the bedroom near the most recent function of the most recent function of the subservation with during a tour of the subservation in	EATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Edroom near the dining as "Fail" for the most testing of the manual a. Based on interview at d review, the Area o other documentation review for the r or replacement of the smoke detector and e smoke detector in the e dining room failed the tional testing of the a system. Based on the Program Director he facility from 11:40 a. on 05/14/13, the a the bedroom near the		3025 GF		E	(X5) COMPLETION DATE
dining room is ha alarm system.	ard wired to the fire					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet Page 6 of 11

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION		A. BUII	LDING	01	COMPL	
		15G606	B. WIN	G		05/14/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	IANA INC				REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A83.470(j)(1)(i) LIFE SAFETY COPROMPT Where an automainstalled, for either coverage, the system in a The adequacy of documented to the jurisdiction. Exception No. 1: If facilities, an automacordance with Normal two Family Documented in sq. ft. and in bather sq. ft., provided the providing a 15 min Exception No. 2: If Exception No. 3: If evacuation capaba automatic sprinkled with NFPA 13, State of Sprinkler Systems are not required in sq. ft and in bather sq. ft., provided that in the providing a 15 min Exception No. 3: If evacuation capaba automatic sprinkled with NFPA 13, State of Sprinkler Systems are not required in sq. ft and in bather ft., provided that	DDE STANDARD atic sprinkler system is at total or partial building atem is in accordance with 3.5.2 and activates the fire accordance with 33.2.3.4.1. The water supply is a authority having In prompt evacuation matic sprinkler system in NFPA 13D, Standard for Sprinkler Systems in One wellings and Manufactured and Automatic sprinklers in closets not exceeding 24 rooms not exceeding 55 hat such spaces are and plaster or materials mute thermal barrier. Not applicable In prompt and slow willity facilities where an are system is in accordance andard for the Installation arms, automatic sprinklers in closets not exceeding 24 ooms not exceeding 55 sq. such spaces are finished ter or material providing a			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
	evacuation capab including four stor accordance with N	In prompt and slow vility facilities up to and ries in height, systems in NFPA 13R, Standard for Sprinkler Systems in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet

Page 7 of 11

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	A. BUILDING	E CONSTRUCTION 01	COM	TE SURVEY IPLETED 14/2013
		13G000	B. WING			14/2013
	ROVIDER OR SUPPLIER PIANA INC		3025	EET ADDRESS, CITY, STATE, 2 5 GREENHILLS LN S IANAPOLIS, IN 46222	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
TAG	Residential Occu	pancies up to and Including eight, are permitted.	TAU			DAIL
	Exception No. 5:	Not applicable				
	system is not req	Initiation of the fire alarm uired for existing cordance with 33.2.3.5.5.				
	installed, for eithe coverage, the sys Section 9.7 and a system in accord	atic sprinkler system is er total or partial building stem is in accordance with activates the fire alarm ance with 33.2.3.4.1. The water supply is documented aving jurisdiction.				
	Exception No. 1:	Not Applicable				
	Exception No. 2:					
	evacuation capable automatic sprinkle with NFPA 13, Strong Sprinkler System are not required in sq. ft. and in bath sq. ft., provided the finished with lath	In prompt and slow bility facilities where an er system is in accordance andard for the Installation ems, automatic sprinklers in closets not exceeding 24 rooms not exceeding 55 hat such spaces are and plaster or material nute thermal barrier.				
	evacuation capable including four sto accordance with the Installation of Residential Occu	In prompt and slow bility facilities up to and ries in height, systems in NFPA 13R, Standard for Sprinkler Systems in pancies up to and Including eight, are permitted.				
	Exception No. 5.	Not Applicable	1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet

Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		15G606	B. WING		05/14/2013
NAME OF D	ROVIDER OR SUPPLIE	D	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI ELE	K.		REENHILLS LN S	
REM-IND	DIANA INC		INDIAN	IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Exception No. 6:	Initiation of the fire alarm			
	system is not required for existing installations in accordance with 33.2.3.5.5.				
	IMPRACTICAL Where an autom	atic sprinkler system is			
		er total or partial building			
		stem is in accordance with			
		activates the fire alarm			
	•	lance with 33.2.3.4.1. The			
		water supply is documented aving jurisdiction.			
	33.2.3.5.2.	aving junisalisation.			
	Exception No. 1:	Not Applicable.			
	Exception No. 2:	In slow and impractical			
	•	bility facilities, an automatic			
		in accordance with NFPA			
		or the Installation of			
		ns in One and Two Family anufactured Homes, with a			
	•	supply, is permitted. All			
		and closets are sprinklered.			
		lers are not required in			
		xceeding 55 sq. ft., provided			
	•	are finished with lath and als providing a 15 minute			
	thermal barrier.	ale providing a 10 millione			
	Exception No. 3:	Not Applicable.			
	Exception No. 4:	Not Applicable.			
	Exception No. 5:	In impractical evacuation			
	capability facilitie	es up to and including four			
		systems in accordance with			
		dard for the Installation of			
	Sprinkler System Occupancies up	to and Including Four			
		, are permitted. All			
		•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet

Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '			X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	BUILDING 01			COMPLETED	
		15G606	B. WIN			05/14/2	013	
	ROVIDER OR SUPPLIER			3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S			
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	Automatic sprinkl bathrooms not ex that such spaces plaster or materia thermal barrier.	nd closets are sprinklered. ers are not required in sceeding 55 sq. ft., provided are finished with lath and als providing a 15 minute						
	system is not req	Initiation of the fire alarm uired for existing cordance with 33.2.3.5.5.						
	Based on observe facility failed to sprinkler heads in maintained. NFI Installation of Space Residential Occurrence Including Four Space 2-4.5.7 states escent a recessed shall be part of an assembly. This confect all clients, affect all clients, Findings included Based on observe Director during an 11:40 a.m. to 12 bedroom near the sprinkler head long escutcheon plate opening into the interview at the terrogram Director during and the sprinkler head long the specific plate opening into the interview at the terrogram Director during and the sprinkler head long the specific plate opening into the interview at the terrogram Director during and the specific plate opening into the interview at the terrogram Director during and the specific plate opening into the interview at the terrogram Director during and the specific plate opening into the interview at the terrogram Director during and the specific plate of the	ation and interview, the ensure 1 of over 20 in the facility were PA 13R, Standard for the prinkler Systems in apancies up to an attories in Height, Section cutcheon plates used to a or flush-type sprinkler listed sprinkler deficient practice could staff and visitors.	K01	1S056	The Maintenance Supervisor is requested that USAutomaticrepair/replace the eschutcheon plate that was not to be missing. This repair was completed on 5/18/2013. Please see attachment. The Maintenance Supervisor was be retrained on ensuringthat a recommendations made by USAutomatic will be followed us on in a timelymanner. Ongoing, the Maintenance Supervisor will stay in constant contact with the contact from USAutomatic to ensure the all work and updates are completed and followed up with the completion Date: June 17, 2007. Responsible Party: USAutomatic Maintenance Supervisor of Indiana Mentor.	will II up oct nat h.	06/17/2013	
		cutcheon plate which left						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet

Page 10 of 11

PRINTED: 06/05/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G606	A. BUILDING B. WING	01 	COMPLETED 05/14/2013
	PROVIDER OR SUPPLIER DIANA INC		3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S IAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	a two inch openi	ng into the ceiling.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4ZI621

Facility ID: 001175

If continuation sheet Page 11 of 11